MINUTES OF THE
LEGISLATIVE COMMISSION'S BUDGET SUBCOMMITTEE
January 23, 2019

The Legislative Commission's Budget Subcommittee was called to order by Chair Maggie Carlton at 8:36 a.m. on Wednesday, January 23, 2019, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/79th2017.

ASSEMBLY COMMITTEE MEMBERS PRESENT:

Assemblywoman Maggie Carlton, Chair
Assemblywoman Teresa Benitez-Thompson, Vice Chair
Assemblyman Jason Frierson
Assemblywoman Sandra Jauregui
Assemblyman Al Kramer
Assemblywoman Daniele Monroe-Moreno
Assemblywoman Dina Neal
Assemblywoman Ellen B. Spiegel
Assemblyman Michael C. Sprinkle
Assemblywoman Heidi Swank
Assemblyman Tyrone Thompson
Assemblywoman Robin L. Titus
Assemblyman Jim Wheeler

SENATE COMMITTEE MEMBERS PRESENT:

Senator Kelvin Atkinson
Senator Yvanna D. Cancela
Senator Moises Denis
Senator Pete Goicoechea
Senator Ben Kieckhefer
Senator David R. Parks
Senator James A. Settelmeyer
Senator Joyce Woodhouse

COMMITTEE MEMBERS EXCUSED:

Assemblyman John Hambrick

STAFF MEMBERS PRESENT:

Cindy Jones, Assembly Fiscal Analyst
Mark Krmpotic, Senate Fiscal Analyst
Sarah Coffman, Principal Deputy Fiscal Analyst
Alex Haartz, Principal Deputy Fiscal Analyst
Carmen Neveau, Committee Secretary
Lisa McAlister, Committee Assistant

After roll was called, Chair Carlton reminded those present to turn cell phones off and, when testifying, to sign in for the meeting, to leave a business card with the committee secretary, to state the testifier's full name, title and agency, and to repeat his or her name each time the testifier spoke. Further, Chair Carlton asked testifiers to define all acronyms, and to leave written copies of all testimony with the committee secretary.

Chair Carlton reminded the audience of the two-minute time limit for public comment and then opened the meeting for public comment.

Steven Cohen, a private citizen from Las Vegas, Nevada, explained that his testimony was longer than two minutes, but he would try to summarize. The topics he addressed included reimbursement rates and quality assurance. He differentiated between paying for services and paying for quality services. Nevada had one of the lowest reimbursable overhead rates in the country, and the rate needed to change. Firms subcontracting to Nevada government were going out of business, and children under the Aging and Disabilities Service Division, Department of Health and Human Services, were sitting on a waitlist for a minimum of one year. He granted that there was a potential allocation to reduce the waitlist, but the longer people went without services at a young age, the lower quality of life those people would lead. He explained that he, at the age of 30, was evidence of a lack of intervention services at an early age.

Mr. Cohen's written testimony, as revised on January 28, 2019, was included as (Exhibit C).

Todd Sklamberg, Chief Executive Officer, Sunrise Hospital and Medical Center, and Sunrise Children's Hospital, Las Vegas, Nevada, (Sunrise Hospital) requested support for critical services that Sunrise Hospital provided to the Medicaid population. He was encouraged and grateful for Nevada Governor Steve Sisolak's decision to include Medicaid rate increases for providers of neonatal and pediatric intensive care units in The Executive Budget. As the largest provider of Medicaid services in the state, and the only provider of several services that helped the most vulnerable members of the community, Sunrise Hospital was committed to the continuation of this care, but needed help. As a result of the Patient Protection and Affordable Care Act and Medicaid expansion, the Medicaid population in Clark County had exploded, he stated, and Medicaid now covered 42 percent of Sunrise Hospital's inpatients, and 56 percent of emergency room patients. He continued to explain that in Nevada, Medicaid reimbursed hospitals at 57 percent of costs, compared to 70 percent in Arizona, 82 percent in California, and 100 percent in Idaho.

Mr. Sklamberg highlighted several complex and costly services provided at Sunrise Hospital, including, but not limited to, pediatric open heart surgery (where the hospital had an average loss of almost $30,000 per Medicaid patient), the neonatal intensive care unit (which lost $7.5 million dollars on Medicaid services in 2017), and obstetrics (where the five thousand babies born translated to Medicaid losses of over $9 million dollars). He requested support of the Medicaid rate increases for providers of neonatal and pediatric intensive care units, as well as support for higher reimbursement rates for hospitals like Sunrise Hospital, so Sunrise Hospital could continue to provide the best care for everyone in Nevada. Hospitals, he concluded, could not sustain Medicaid losses of $77 million every year.

Katie Roe Ryan, Director, Public Policy and Advocacy, Dignity Health, St. Rose Dominican Hospitals, echoed Mr. Sklamberg's gratitude regarding the recommended reimbursement rate increases and stated that St. Rose Dominican had approximately 500 babies that entered the Level 3 Neonatal Intensive Care Unit at the Sienna Campus every year. These babies were some of the most fragile patients seen in the hospital. Because of their size at birth, the babies were premature, critically ill, or had a medical condition that required special care. Over the past ten years, the hospitals had seen an alarmingly large increase in the number of babies born dependent on substances taken by the mother during pregnancy, known as neonatal abstinence syndrome (NAS). Nevada, she stated, had nearly double the national average for NAS babies, and the opioid epidemic was a contributing factor. She concluded by referencing a great state-funded program, Empowering Mothers for Positive Outcomes With Education, Recovery, and Early Development (EMPOWERED) and again expressed her gratitude for the proposal to increase the Medicaid reimbursement rate.

Gina Hernandez, Business Director, Sun Valley Surgery Center, North Las Vegas, Nevada, discussed dental outpatient surgery center procedures for Current Procedural Terminology code 41899. Ms. Hernandez indicated reimbursement for this code decreased last year by approximately 50 percent, and most outpatient surgery centers in Las Vegas discontinued these procedures for children and adults with special needs, leaving Sun Valley Surgery Center as the only outpatient facility for this procedure. She asked for help reinstating the allowable reimbursement for this service. Because Sun Valley Surgery Center was now the only facility providing the service, the situation had been called a crisis. The facility saw 300 patients who needed this procedure last month, and that number would continue to increase because dentists had nowhere else to send patients. She believed there was one facility in Reno that saw patients with this need, but only one day a week. She apologized because her administrator had planned to testify but was the physician-on-call today. She concluded by explaining that Sun Valley Surgery Center was taking a loss on every case the facility handled, and the facility could only experience so much loss before it could no longer serve children and would have to close.

Cecilia Martinez, a private citizen from Clark County, testified in support of the Nevada Educational Choice Scholarship program. She wanted to share her daughter's story and explain why the program was vital to her daughter's needs as a Nevada student.

Ms. Martinez read the following statement into the record:

My husband I are parents to an amazingly bright and very verbal 11-year-old girl with Down syndrome. The hardest, most frustrating, exhausting (both emotionally and physically), disappointing, terrifying, and disheartening part of raising our child has been educating her within the Clark County School District (CCSD). Before having our daughter, we believed "separate, but equal" was only found in history books, but that could not have been further from the truth. Our daughter has always been different, even for someone with her condition. As the years passed, we realized that a self-contained classroom setting was not appropriate for her and so began our nightmarish fight for our daughter's educational rights.

If CCSD was capable of meeting the educational needs of our daughter:

- Principal Heather J. Lenz would not have repeatedly obstructed my daughter's federal right to free appropriate public education in the least restricted environment.

- Our family would not have suffered additional economic hardship due to advocate and attorney's fees in order to be supported and prepared at every one of our daughter's Individualized Education Plan, Behavior Intervention Plan, and procedural meetings.

- We would not have had to file for mediation in 2016 to get her into an appropriate educational setting.

- We would not have had to file for due process in 2017 for the exact same reason.

- We would not have had the majority of our requests to observe our daughter in school denied by Principal Heather J. Lenz since spring 2016, nine of which were submitted during the current school year.

- Our resolution request to observe our daughter during her library special and in order to leave with whatever books she checked out for our Public Concern Form filed in 2017 would not have been denied by Principal Heather J. Lenz, Dr. Celese Rayford, Dr. Mike Barton, and Mr. Joseph Caruso on behalf of Superintendent Pat Skorkowsky.

- Our request for sample work from the general education teachers to justify her failing grades would not have been ignored.

- Our daughter would have participated with her typical peers in classroom activities such as vocabulary tests instead of being excluded via alternative assignments.

- Our daughter's dignity would still be intact since she never would have exhibited inappropriate behaviors such as sucking her thumb in school.

- We currently would not be terrified to send our daughter to public school.

- Our daughter would still be attending Jay W. Jeffers Elementary School.

- We would not have been forced into homeschooling while scrambling to find a school capable of meeting our daughter's educational needs.

Education is not a one size fits all and, worse yet, not something Nevada should be cutting funds and/or options for. Our child's educational career is suffering; please help. Please support the Nevada Educational Choice Scholarship program. As Dr. Martin Luther King, Jr. said, "the time is always right to do what is right." Thank you for your time and attention.

Seeing no one else from Las Vegas or Carson City with public comment, Chair Carlton recognized the Department of Health and Human Services. As long as the Supplemental Nutrition Assistance Program (SNAP) was on everyone's mind, the Chair asked for that topic to be discussed first.

Richard Whitley, Director, Department of Health and Human Services, (DHHS), explained that the government shutdown that occurred on December 21, 2018, was a partial shutdown because not all departments were immediately affected. He clarified that because DHHS determined eligibility in a coordinated manner, there was confusion among clients in regard to the services being affected. The United States Department of Agriculture (USDA) was one of the government agencies impacted by the partial shutdown, and USDA funded the food support programs, such as SNAP, Women, Infants and Children (WIC), and commodities, such as food that went to Three Square, the Foodbank of Northern Nevada, and school lunch programs. The USDA administered a comprehensive program that addressed food security for families who could access multiple programs.

The first priority for DHHS after the shutdown was the February benefits because the shutdown had already lasted longer than any government shutdown he had experienced. He was grateful that USDA leadership had called all states and was able to get the February benefits uploaded in January. The downside of having the SNAP February benefits available to SNAP recipients early was that if the February benefit was spent too quickly, there could be a shortfall. The office had tried messaging retailers and consumers to let the recipients know about the potential for a shortfall. The challenge would be if the shutdown continued beyond February. Conference calls with USDA were continuing every other day to discuss the consequences. He suspected that there may have been an opportunity in March for additional funding, but no details had been provided yet.

Mr. Whitley contacted USDA to ask whether there was an opportunity for states to use State General Fund or other funding sources to fill the gap and be reimbursed by USDA, but he had not heard back. The USDA had previously said that there was a risk to states that attempted to fund in this manner, but Mr. Whitley wanted to see the risk identified in writing. He also wondered whether the March funding would be partial or full funding, and what the gap might be. He had conference calls both with the Office of the Governor and Legislative Counsel Bureau (LCB) staff, and his intent was to keep legislative leadership and LCB staff informed each time new information was received. Mr. Whitley noted that new information was received daily. He restated that the pressing priority for DHHS was to get February benefits established. He recalled that the *Nevada Independent* had a visual depicting the effects of the government shutdown beyond the consumer to show the revenue generated from SNAP to retailers, by county. This was an important consequence for Nevadans, especially to stores that catered to those in poverty and depended on the revenue generated from SNAP funds. Other than keeping retailers informed, there was not much that he could do about it, however.

Chair Carlton clarified that USDA was where the SNAP benefits originated, and she defined several acronyms that Mr. Whitley had used. She further stated that the SNAP amount was about $54 million per month and asked whether that was correct. Mr. Whitley confirmed that the actual food value was approximately $51 million, and the administrative costs made up the rest of that amount.

Chair Carlton asked about the administrative cost and the roughly 400 employees that were paid, at least partially, by these federal revenues and whether state employees would be affected by the government shutdown. Mr. Whitley stated that Chair Carlton was correct and the strategy for the workforce was different. The administrative costs were covered through February, but if the funding ended in March, the workload would be shifted to other eligibility programs to the degree possible. He discussed the disruption associated with placing employees in other capacities and the risk of losing capacity for eligibility. He noted that the Division of Welfare and Supportive Services, Department of Health and Human Services, did a good job of cost-allocating eligibility workers among Temporary Assistance for Needy Families (TANF), Medicaid, and SNAP, but he noted that it was a fragile system, and if one thread was pulled out, there was a possibility that the eligibility process would be disrupted.

Chair Carlton opened the meeting up for questions from the Subcommittee members.

Assemblyman Sprinkle asked about Mr. Whitley's statement that the SNAP program was covered for February and whether by "covered" Mr. Whitley was referring to federal dollars, or whether the state was covering the benefits, and what would happen in March when the dollars were not there. Mr. Whitley replied that for the actual benefit loaded to the Electronic Benefits Transfer (EBT) card, the dollars did not come to Nevada, but were loaded onto the cards and the bill was paid by the federal government through USDA, although the subsequent revenue to the retailer was generated in Nevada.

Assemblyman Sprinkle wondered about the state's position to continue benefits for Nevadans when the cards were not loaded with benefits for March. Mr. Whitley said that the benefits were paid with federal funding, so there was no plan to subsidize the benefit with state dollars. That was why Mr. Whitley felt the daily updates to strategize were important, especially because other federally funded food programs would also be affected in March. The SNAP program, according to Mr. Whitley, was the biggest program in regard to the number of people who benefitted, but other food programs would also be at risk for funding in March. The WIC program covered a vulnerable population—women who were pregnant or had children under the age of five and were living in poverty—and had wraparound services for prenatal healthcare. All the USDA funded programs carried the same risk.

Chair Carlton asked about the WIC numbers, what the dollar impact would be, and the amount of WIC federal dollars that were given to Nevada. Mr. Whitley did not have this information, but explained that Julie Kotchevar, Ph.D., Administrator, Division of Public and Behavioral Health, DHHS, would provide that information.

Chair Carlton acknowledged the negative domino effect and the $51 million in SNAP funding that would otherwise come to Nevada and would ripple to local grocery store employees who worked extra hours around the first of each month.

Assemblywoman Jauregui asked about the number of families in Nevada who were SNAP recipients. Mr. Whitley replied that approximately 433,000 recipients benefitted from SNAP funding.

Assemblywoman Monroe-Moreno asked what date in February the March benefits would be uploaded to EBT cards because this date would be a good indicator of trouble. Mr. Whitley replied that he did know the date. He noted that if the federal government partially funded SNAP, then Steve H. Fisher, Administrator, Division of Welfare and Supportive Services, DHHS, had determined when other funding sources could be added, if available, as a subsidy on the EBT cards. That detail, he stated, was coming in, but he did have the date and the mechanism for how to upload other funding services so a well-informed decision could be made.

Assemblyman Thompson noted that a few businesses in his district had signs posted since the beginning of January stating that the businesses no longer accepted EBT cards. He wondered whether there was an enforcement mechanism that could be used to encourage businesses to continue to accept EBT cards or whether that was left to the discretion of the businesses. Mr. Whitley stated that this was a separate level of interaction regarding the stores' qualifications to be SNAP providers. Mr. Whitley wondered whether the stores had changed their policies for accepting EBT cards, but he did not believe that the government shutdown was the reason for the signs. It also could have been a misunderstanding so he volunteered to reach out to the businesses.

Assemblywoman Benitez-Thompson asked whether the USDA programs included the commodity boxes and food programs for seniors. Mr. Whitley confirmed that the programs included commodities, such as the Foodbank of Northern Nevada and Three Square which received commodity funding through the USDA. Those programs were on the same timeline. Meals on Wheels, he noted, was funded through a different federal agency, so there would be no problem with the shutdown. Only the USDA was affected by the shutdown, and Mr. Whitley said he would provide a list of the specific programs. He was also trying to pull data to identify the consumer groups that had touch points and relied on all the programs in total. Mr. Whitley noted that Jodi Tyson, Vice-President of Strategic Initiatives of Three Square, reported that over 40 percent of people who accessed commodity foods through the pantries also used SNAP. By itself, SNAP was not enough to feed a family, so people would tap into other sources and overlap the services.

Mr. Whitley stated that SNAP clients were working, but lived in poverty, with multiple people in a family relying on a single income. Clients were not typically unemployed, but were working and struggling to make ends meet. Another statistic quoted by Mr. Whitley was that 90 percent of the people receiving SNAP benefits were also on Medicaid. This factor was difficult for Mr. Whitley, as the Director of the DHHS to grasp, as nutrition was a determinant of health, and he had run the data to determine disproportionately how many SNAP and Medicaid clients also had diabetes and how many were struggling with issues where food was an influence. Since Medicaid was not affected by the government shutdown, paying for healthcare was not affected, but SNAP, the determinant of health, was affected. He reiterated that 90 percent of the people enrolled in SNAP were also enrolled in Medicaid.

Chair Carlton sought other questions from Subcommittee members, and hearing none, she opened the meeting for presentations.

Richard Whitley, Director, Department of Health and Human Services, stated that his presentation would include a brief overview of (Exhibit D), "Department of Health and Human Services, 2020-2021 [2019-2021] Governor Recommends Budget, Pre-Session Budget Hearing," dated January 23, 2019. He explained that pages 2 and 3 of Exhibit D covered the mission of the Department and its statutory authority. The Department, he said, was divided into agencies or divisions, and services fell within broad categories of eligibility that included paying for services, regulating services, and delivering direct services. Some divisions conducted all of those services at one time, which could be challenging. The Division of Welfare and Supportive Services, Department of Health and Human Services, determined eligibility, the Division of Health Care Financing and Policy, Department of Health and Human Services, paid for healthcare, and the three remaining divisions both delivered services and oversaw the delivery of services. The direct need and delivery of service versus building community systems to deliver services tugged the Department in different directions and was challenging, especially as the Department tried to fully develop several systems.

Another challenge for the Department during the interim was to review the proposals to repeal and replace the Patient Protection and Affordable Care Act (ACA) and the

consequences to the expansion of Medicaid. He had hoped for the opportunity to focus on the health care system, because the prior effort had been directed toward increasing the number of persons eligible for Medicaid and dramatically reducing the number of uninsured Nevadans. The next phase needed to focus on the health care system. He wanted to look further at where people went to find health care services, whether the systems were quality systems, and whether the systems met the needs of the clients. That effort, however, was affected by the number of proposals directed at changing the ACA and the expansion of Medicaid. Mr. Whitley felt that the Department was in a good place with Medicaid, regardless of other proposals received or the experiences with the SNAP that he discussed earlier and the effects that other federal programs could have on SNAP.

Mr. Whitley next discussed the focus on access to healthcare, as laid out on page 4 of Exhibit D. Regarding access to healthcare and mental health services, he was pleased with the largest proposed State General Fund increase for mental health services in a decade. The increase, he noted, did not include Medicaid coverage for mental health services, but involved dedicated State General Fund dollars. Providing access to healthcare in much of Nevada was limited by a workforce shortage, and even more so because of shortages in some specialties, in both urban and rural areas. The focus was whether the funding maximized the scope of practice for clinicians and to not rely on "physician-only" practices when the service could be provided by another provider type. For example, the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) proposed a bill to extend diet recommendation privileges to dieticians, much as the Centers for Medicare and Medicaid Services allowed in hospitals. In the 77th Session (2013), the Legislature enacted major changes to independent practice for Advanced Practice Registered Nurses (APRNs). He believed the state had not fully maximized the pay parity opportunity. One of the pay parity gaps was in the area of obstetrics and gynecology, working with the nursing board and nurse midwives for adequate reimbursement. Nevada ranked poorly in access to prenatal care and the incidence of "drop-in" deliveries. Partnership with the universities needed to continue in a focused way, he stated, not just for medical graduate school, but also for other health care education because of shortages in other medical-related disciplines.

Mr. Whitley stated that the next bullet on Page 4 of Exhibit D focused on maximizing revenue. As an example, Assemblyman Sprinkle's working group looked at the Nevada health care plan and how maximizing the purchase of healthcare could benefit a greater number of Nevadans. In the course of that study, the Purchasing Division, Department of Administration, conducted a Request for Information, and found that there was opportunity to save money if departments worked collectively. He noted that the most costly individuals to treat were those involved in the criminal justice system [inmates and former inmates]. Those clients also required the most assistance to navigate the health care network. Treating these individuals, he added, might reduce or prevent recidivism.

The Health Care Committee, Mr. Whitley said, identified opportunities for whole health such as improved purchasing power under Assemblyman Sprinkle's bill, as well as other opportunities to purchase healthcare, to purchase medication, and durable equipment, and other efficiency items identified in the Request for Information [note: not all were

recommended by the interim committee]. Mr. Whitley stated that testimony on Senate Bill 265 of the 79th Session (2017), a pharmaceutical transparency bill sponsored by Senator Yvanna Cancela, revealed that Medicaid could recoup more dollars if the Department retained the purchasing power of pharmacy within Medicaid and did not parcel the purchasing out to managed care. That insight led the Department to consider other potential changes in how it conducted health care business.

Mr. Whitley discussed the next bullet on page 4 of Exhibit D, work force, and explained that the bullet covered the need to work closely with universities to produce clinicians who were relevant to Nevada needs and how to keep those clinicians in Nevada. Social work and psychology interns needed to be kept in Nevada so they would want to seek employment in Nevada. Criminal justice involvement was another system where the more upstream you went, the greater the opportunity to prevent costly incarceration. This budget demonstrated the Governor's commitment to enhanced mobile outreach, an incarceration prevention strategy where the Department could intervene with clinical services when someone experienced a crisis, and the Department would not be forced to rely on law enforcement intervention. These priorities, he concluded, were themes that would be seen in all DHHS division budget presentations.

Mr. Whitley covered page 5 of Exhibit D, titled General Funds by Division, 2018-2019 and 2020-2021 Biennia [2017-2019 and 2019-2021 biennia]. He said that the State General Fund recommendation was just over $3 billion and the growth was about 21 percent from the 2017-2019 biennium. The increase was primarily due to federal participation changes. As the economy improved, the match amount the state contributed also increased. This dynamic would also be seen in the Medicaid presentation with amounts broken out for each population served. Other factors for an increase in funding, he noted, were caseload growth, mandates, and inflation.

Mr. Whitley said that page 6 of Exhibit D, titled Budgeted Funding Sources, 2018-2019 and 2020-2021 Biennia, [2017-2019 and 2019-2021 biennia], showed the breakout by funding source. The budgeted federal funds held steady at 62 percent of the budget for the 2019-2021 biennium from the 2017-2019 biennium, and the state funds increased from 23 percent to 24 percent. The remaining 14 percent in recommended revenues were from other funding sources that included fees and tobacco settlement dollars.

Mr. Whitley explained that page 7 of Exhibit D showed over time the staffing needs of the DHHS. There were approximately 6,000 employees, and the increase in workforce was primarily attributed to caseload growth and mandates for the Division of Children and Family Services, DHHS, related to juvenile justice.

Page 8 of Exhibit D, Mr. Whitley said, was Bill Draft Requests, some of which were policy bills and some of which were budget bills. On page 10 of Exhibit D, he highlighted the Summary of Director's Office Operations, including oversight within the agencies, and several grants and funding streams administered directly out of Mr. Whitley's office.

On page 11 of Exhibit D, he said that the majority of funding for the DHHS Director's Office

was "other," made up of the tobacco funding and ad valorem property taxes and unmet freecare obligations. He continued by explaining that page 12 of Exhibit D included a summary by budget account, and page 13 of Exhibit D included a summary of major enhancements.

This first enhancement, Mr. Whitley continued, was improved department wide auditing and grants management, and making improvements in how oversight was conducted for grants received. Over the past two years, federal and Legislative Counsel Bureau audits identified that multiple programs within the Department were funding the same agencies but that there was no communication between programs to identify matters of concern or findings or even to coordinate nonprofit audits or site reviews at a local level. Because the DHHS received more grants than any department in state service, he commended Julia Peek, Deputy Director, DHHS, and her efforts to secure the available federal funding. When the economy had not performed well and budget cuts were necessary, Mr. Whitley had tried to minimize the consequences to communities, but where he did not have staff available, it showed in the audits. For some grants, he chose not to take the full administrative amount to make more funds available to the individuals who needed funding. Had Mr. Whitley not addressed auditing and management support in the budget, however, the Department could potentially risk future grant funding.

The second enhancement, Mr. Whitley said, covered program transfers to align services. Tobacco or gambling funding tended to fluctuate and when Medicaid had a corresponding service, it was important to align the programs. Gambling, he stated, was an addiction that could be prevented and treated. Many of the services provided paralleled services already provided under the Division of Public and Behavioral Health, DHHS. A judge in Las Vegas, he noted, operated a specialty court for gambling addictions. Aligning the problem gambling with other addictions made sense from a programmatic side. And he noted that food security was the same. He had partnered the Women, Infants and Children (WIC) program with the Supplemental Nutrition Assistance Program (SNAP) because both programs were nutrition-based; and often both programs provided services to the same family in a coordinated way. Likewise, the Department supported food security and had a food security council that needed to be working off the same plans as other programs and filling the same gaps that federal programs did not fill. The last program alignment matter was to transfer the Child Abuse Prevention and Differential Response activities to the Division of Child and Family Services (DCFS), DHHS.

The Family First Act that Ross E. Armstrong, Administrator, DCFS, DHHS, would discuss later, required DHHS to focus on prevention and intervention. In the past, DCFS had focused on services and need. Lines were long and needs existed, but if the Division did not get upstream and take action to prevent child abuse and child neglect, there would be no reduction in the number of abuse cases. The federal initiative for prevention and intervention required these dollars to be coordinated with the DCFS.

The final enhancement, according to Mr. Whitley, provided staffing to address consumer protection. This enhancement was included by Governor Steve Sisolak to address conflict between a provider and a health plan because the consumer was often put in the middle of these disputes. This enhancement fit well under the Office of Consumer Health Assistance, DHHS, because the staff functions included billing mediation matters and navigation of the complex health care system. He hoped that there was a companion piece in policy to help with the detail because without policy his department would make the service available, but with limited accountability. Some states, he noted, had seen benefits with this policy when the administrative decisions were binding, but Mr. Whitley stated that he looked forward to working with any policy that might be related to consumer protection.

Mr. Whitley continued to page 14 of Exhibit D, the Healthy Nevada Funds, and explained that the Healthy Nevada Funds were tobacco settlement funds. The revenue had remained steady over the past 10 years, with a 6 percent increase in the past 2 years. There had, however, been a change in the reliance on these tobacco dollars because services once funded with tobacco funds were now covered by Medicare, or in programs such as Senior Rx where an out-of-pocket gap, known as the "donut hole," that was not covered by Medicare Part D had been reduced. The shorter period when consumers needed supplemental payments had reduced the need for some of the tobacco funding.

Mr. Whitley said the detail on page 15 of Exhibit D illustrated the changes in the use of tobacco funding. Senior Rx funding had decreased because it was caseload driven. He stated that more information would be provided in the Aging and Disability Services Division, DHHS, presentation. The other example, he continued, was the Federally Qualified Health Center (FQHC) Incubator Project, adding to the capacity for providing healthcare. In the last session an incubator project was added for persons who were criminal justice involved, which worked with FQHCs to provide more specific services for those released from jail, particularly from the Clark County Detention Center and the Washoe County Detention Center. In the past, eligibility workers had been placed in those settings, and eligibility for Medicaid and SNAP was determined. The incubator project helped the former detainees to find and receive those services. Mr. Whitley proposed to generate a new Request for Proposal for an incubator project for children's health, both in school and nontraditional sites outside of school, focusing on a different population than the last incubator study. The League of Women Voters of Nevada and the Primary Care Office, Division of Public and Behavioral Health, DHHS, had reached out to Mr. Whitley about other project areas for other populations. He said that children accessing healthcare was a priority and an area where he realized children caught up when they entered school, but only because immunization requirements mandated a medical encounter. Mr. Whitley noted that the federal government had provided the opportunity for FQHC's. Nevada would benefit from more FQHC's which were safety net providers that could not deny anyone access to service and, in turn, received an enhanced Medicaid rate.

Mr. Whitley continued with a discussion of the recommended enhancement in the mobile outreach and mobile crisis line items, which included some State General Fund. The intervention services functioned to prevent criminal justice involvement and to prevent

emergency room visits and were supported with reimbursement from Medicaid, State General Fund, and tobacco funds. Operationalizing these services would expand the hours in Clark County and Washoe County to 24-hours and would also enhance capacity in rural areas. The final program to benefit from tobacco funding, he explained, was autism support, where the funding would be used to address the wait list and to provide reimbursement for services.

Mr. Whitley next referred to page 16 of Exhibit D, where he introduced the Social Services Block Grant (Title XX). The block grant subsidized state agencies for services, much like the state agencies received State General Fund, and it had been a funding source used to supplement the DHHS divisions. Similarly, this page showed some pass-through funding to counties for child welfare.

Referring to page 17 of Exhibit D, Mr. Whitley discussed the Office of Consumer Health Assistance. This office had been discussed earlier, as an enhancement, and was a workforce program using people with subject matter expertise in healthcare to assist consumers with health care system challenges such as complaint resolution, disputes, and system navigation. As healthcare became more specialized, the need for navigational assistance, and the need to determine what services were covered became even more important to consumers. Mr. Whitley believed that over time, his department had done a good job of appropriately cost-allocating this function to each specific program, and he wanted to continue the cost allocation as changes in healthcare evolved.

Starting on page 18 of Exhibit D, Mr. Whitley referred to two pass-through programs managed in his office that help to subsidize Medicaid. The first program was indigent hospital care which used two sources of revenue: the ad valorem tax and the unmet indigent freecare obligation. Because DHHS had done a better job of getting people insured or covered, the hospitals had not been able to provide as much indigent freecare. In lieu of that unmet indigent freecare obligation, a fee was charged by DHHS to supplement Medicaid. He explained that with Medicaid, the state portion, including State General Fund, was made up of several funding streams, one of which was the indigent freecare obligation, used to subsidize the cost of healthcare. He reminded the Subcommittee that Medicaid was typically the lowest payer under the Medicare rate, and some of these programs subsidized hospitals for the uncompensated care and for serving as a safety net provider.

On page 19 of Exhibit D, he highlighted another funding stream, the Upper Payment Limit (UPL) Holding Account, another pass-through account associated with private hospitals that was used to subsidize Medicaid. In this case, the Nevada Clinical Services, Inc., a nonprofit corporation in Nevada, as part of charity care initiative, assumed some of the contracts for the state and transferred the supplemental payments to Medicaid; some of those funds were reverted to the State General Fund. This budget included the transfers to Medicaid of approximately $8 million and reversions to the State General Fund of between $5 million and $6 million.

This concluded Mr. Whitley's presentation of the budgets managed by his office.

Chair Carlton asked about the UPL Holding Account and whether this was the program where the hospitals paid in, the state leveraged the money, and the money was returned to the hospitals, in essence, and Mr. Whitley confirmed the Chair's scenario.

Assemblywoman Neal asked Mr. Whitley to discuss recently released offenders, the common problems that arose for treatments, and the difficulty in finding health care services after release from incarceration. Mr. Whitley replied that there was no requirement for an appropriate discharge from a jail. While a person was in jail, health care was a required service, regardless of whether the service was for mental health, substance abuse, or diabetes, and the counties had to pay for the healthcare. The inmate might have been stabilized in jail and given three days' worth of medications at release, but because no appointments were made for the inmate after release and because it was virtually impossible to get an appointment within three days, those discharges might land recently released inmates in crisis because the health care system was not connected.

During the interim, Mr. Whitley continued, DHHS had worked with Northern Nevada HOPES in Reno and FirstMed Health and Wellness Centers in Las Vegas, both FQHCs, to work in tandem with eligibility workers in jails to at least ensure that people with diabetes or serious mental illness had a referral point. He acknowledged that there were no controls in place to ensure released inmates went to medical appointments, but he wanted to make it advantageous for them to follow up on healthcare and to benefit from that action.

The next step for Mr. Whitley was the transportation piece. Typically in urban areas, people with a planned release were released at 4 a.m. For the seriously ill that were released at 4 a.m., there was often no way to get to their destinations. Transportation needed to be aligned to meet this need. At some point, jail healthcare needed to be tied to community healthcare, rather than a private vendor outside of Nevada who would come in and hire contract staff and provide disconnected care. Mr. Whitley envisioned a system that was seamless, and he believed that was the next phase. He clarified that when he stated the prisoner would be released and not land safely, it was not intentional. Mr. Whitley noted that he had trouble navigating his own health care system and finding specialists, so it was likely that released inmates would also experience the same trouble. There was a need, he said, to design a health care system to help folks who had been stabilized in jail and continue their health care services afterwards.

Assemblywoman Neal asked about problem gambling and whether there was crossover between problem gamblers and those who were homeless because of gambling. She also asked whether there were any wraparound services that would be applied in that situation. Mr. Whitley explained that there was not a lot of data for problem gambling, and the addiction disorder may not be identified as gambling. The criminal behavior might be embezzlement with no indication that the cause of the crime was gambling. For this reason, he was excited to partner with the specialty court as well as using it as an intervention point. Problem gambling has not had an investment in a strong prevention arm, unlike other preventable disorders like tobacco or alcohol use. The dollars in this budget would be used to support prevention strategies, but the data component was essential. Mr. Whitley stated

that the University of Nevada, Las Vegas (UNLV) had expertise in gambling addictions, and he noted that DHHS was working with UNLV to mine data from existing UNLV databases. The key was not just being able to extract the data, but to use it to better understand the determinants of problem gambling and whether that behavior could be caught early. At this point in time, DHHS was in the first stages of that effort, but Nevada could be out in front of the data research through the partnership with UNLV.

Assemblywoman Titus noted that healthcare was a difficult field to manage with many moving parts and different payers. Along the line of access to care, she appreciated his recognition of the increase in the number of Medicaid recipients, and his support for other avenues, other resources, and other primary care providers, including nurse practitioners, physician assistants, and primary care doctors. For Assemblywoman Titus, the concern was access to care for diabetics. She asked Mr. Whitley how he was expanding such access to care, not just at the entry level, but also for referrals. Mr. Whitley replied that this was another instance of needing to look at the data to identify the level of problems.

Mr. Whitley noted that historically, DHHS had taken an approach of addressing Medicaid matters statewide, but he had seen a huge benefit from the legislation passed in [Assembly Bill 366 of] the 79th Session (2017) on the regional behavioral health boards. The regional discussions on the services available were important, and it was important to quantify specialty providers. He thought there was a need for community-based plans that would address chronic diseases. He believed DHHS possessed good data on chronic communicable diseases, but needed to make that data useful at a community level and identify specific community special need services. Every community was different, and he wondered who would fill the gap, whether it would be a nurse practitioner, a physician assistant, or a specialty provider. He noted that there had been great gains in telehealth, and while not the answer to everything, telehealth was a tool to help fill gaps. The other part of the equation for people with chronic diseases was paramedicine. Paramedicine involved helping people in their homes and preventing the need to go to an emergency room by providing touch points and follow-up not just for chronic diseases, but for substance abuse cases as well. Mr. Whitley wondered whether any wraparound services could be used for follow-up visits to prevent the next crisis.

Assemblywoman Titus explained that expanding the services covered by Medicaid was important, but she wanted to revisit Mr. Whitley's statement about inmates falling through the cracks after release. She understood that Mr. Whitley was not able to mandate personal health care choices for inmates upon release, but because she recognized that inmates and doctors both had difficulty locating any health records, she wondered if he had considered pursuing a Medicaid-based system, perhaps similar to the Renown Health's MyChart system, to help released inmates access their health care information. Mr. Whitley responded that he had identified record-tracking from community to jail to the Department of Corrections and back to the community as a problem because there was no single system for the paper records at each touchpoint. He acknowledged that he did not have a solution, but he believed that having the records would provide the opportunity to intervene with those who were criminal

justice involved. He accepted that knowledge did not change behavior, but he believed knowledge could help influence behavior. He further believed that people needed to be made aware of the importance of past health records. Developing health literacy was an area where the DHHS could do better.

Assemblywoman Titus noted that everybody had a smartphone, regardless of economics, so she appreciated any attempt Mr. Whitley might make to use the technology.

Assemblyman Thompson asked about autism and the dollars allocated to physician and health care provider awareness and education. Mr. Whitley replied that there was no comprehensive approach, but DHHS did best with early intervention, and opportunities where children were passing through systems. Pediatricians and nurse practitioners with pediatric caseloads could perform well-child checks, but the focused training was not a reimbursable service. Mr. Whitley mentioned that he could look for grant funding, but these specific dollars were going to be used to address the waitlist.

Senator Kieckhefer asked about problem gambling and the funding change from a quarterly slot tax to a dedicated piece of percentage fees. Percentage fees, he said, were dedicated to the State General Fund, and he asked whether Mr. Whitley was prepared to do a specific carve out of a piece of the gaming tax revenue or what the funding mechanism would be. To address the funding source, Mr. Whitley answered that there was a companion piece for the budget bill that had been recommended by an advisory group. It was his understanding the gaming association was supportive of the funding, but it would change the funding stream and bring in more revenue to use for problem gambling.

Senator Kieckhefer remembered an increase for problem gambling and discussions about this matter from the 79th Session (2017). He stated that it was all fungible when the funds came from the State General Fund, with a line item State General Fund appropriation that maintained flexibility and allowed year-by-year prioritizations. However, if revenue streams that were dedicated to specific areas started to be used, the flexibility was reduced in the long term.

Assemblywoman Neal referenced Page 13 of Exhibit D, the recommended consumer health protection bureau, and remembered that Mr. Whitley had stated that there were no teeth for accountability or enforcement. She asked whether the new office would handle a situation when a patient went to a dental provider, was treated, and then saw a second provider and found that the first provider misdiagnosed the matter, but the patient had already paid for the initial services. Mr. Whitley replied that was a good example of how the health care system of authority or oversight was a complex system and was one of the benefits of having the Office of Consumer Health Assistance, DHHS, respond. An event could occur where multiple regulated entities overlapped, such as the dental hygienist, the dentist, the dental office, requiring the need to identify the appropriate place to lodge the complaint for investigation among the various boards. In the past ten years, he noted, strides had been

made in identifying which regulating board was responsible for investigating complaints. His hope was that the health care system was improved because of past complaints and actions taken to address such problems.

Hearing no other questions, Chair Carlton requested the start of the next presentation.

Suzanne Bierman, Administrator, Division of Health Care Financing and Policy (DHCFP), DHHS, stated that this was her eighth day in her position, so she had brought Cody L. Phinney, Deputy Administrator, DHCFP, DHHS, and Vincent "Budd" Milazzo, Chief Financial Officer, DHCFP, DHHS, to assist with the presentation.

Ms. Bierman provided a brief overview of the program shown in (Exhibit E), "Department of Health and Human Services, 2020-2021 [2019-2021] Governor Recommends Budget, Pre-Session Budget Hearing, Division of Health Care Financing and Policy," dated January 23, 2019. Her background was in the Arkansas Medicaid program, and she was looking forward to learning the Nevada program nuances. She noted the federal framework and the rules and regulations from state to state were relatively consistent, with flexibility in benefit design, populations covered, and eligibility. An example of eligibility, she said, was the newly eligible adult population Nevada had chosen to accept. Other differences included service-delivery models and financing of the nonfederal share. She noted that there were lots of opportunities from other states regarding innovations, and she looked forward to continuing to improve the Nevada Medicaid program.

Ms. Bierman discussed page 2 of Exhibit E, the DHCFP mission and vision statements. She touched upon the overall vision to improve the health of Nevadans. While Medicaid was primarily a purchaser of healthcare, she wanted to look for opportunities to work with partners and other agencies, recognizing the critical importance that social determinants played in improving healthcare. She wanted to emphasize the need to promote equal access, recognizing that workforce challenges existed, but looking to the Medicaid program to address those possibilities through funding for graduate medical education and developing new and nontraditional provider types, something that the state had already initiated. Ms. Bierman also wanted to look for opportunities to ensure the adequacy of networks and make sure that individuals served were able to access care. She expressed concern over the growth of health care costs and was looking for opportunities to address that growth. Items to be discussed later, she noted, were initiatives related to program integrity and the need to delve into pharmaceutical programs to find more efficient ways to purchase pharmaceutical benefits. She explained that DHCFP had begun work to maximize federal resources and to provide outreach to providers for Medicaid billing that would identify opportunities to become Medicaid providers in the state.

Ms. Bierman next discussed the scope and the scale of Medicaid. Medicaid was a critically important program that served more than 20 percent of Nevadans. Medicaid paid for more than half of all births in the state, and nationally Medicaid was the largest payer of behavioral health services. Medicaid, she concluded, was a big program with potential to improve the healthcare of Nevadans.

On page 3 of Exhibit E, Ms. Bierman stated that the Division goals were similar to the goals previously presented by Richard Whitley, Director, DHHS, but she noted that the goals remained consistent with past years. The top priorities were ensuring access to services, engaging with providers, and ensuring the development of the full range of settings so individuals had choices in where and how they received needed health care services.

Ms. Bierman next referred to page 4 of Exhibit E and explained the Summary of Agency Operations. Nevada, she said, had a service delivery model which relied on managed care organizations in urban areas and a fee-for-service model in rural areas to provide care. Medicaid provided some services that commercial payers did not provide. The program was unique as it covered long-term care services, nonemergency medical transportation, and other services beyond those commercial payers typically provided.

Ms. Bierman introduced Cody L. Phinney, Deputy Administrator, DHCFP, DHHS. Ms. Phinney discussed page 5 of Exhibit E and mentioned that she was excited about the launch of the final phase of the information management system modernization. The first two phases had been successful, and the final phase would help DHCFP become more efficient with its providers and would allow for the transition to a paperless system. She believed that the DHCFP Medicaid operation would be more nimble, and she would be able to adapt needed policy changes quickly. She explained that DHCFP had expanded from two to three managed care carriers in urban Washoe County and Clark County and had collaborated with the Division of Behavioral and Public Health, DHHS, to use the Certified Community Behavioral Health Clinics Program as a foundation for transforming needed behavioral health care in Nevada and determining how to pay for these services for those who needed such service. The DHCFP had carried out initiatives to ensure the integrity and appropriateness of DHCFP services. These initiatives ensured that high quality services were being purchased and that consumers were protected by the purchase of those services.

Ms. Phinney concluded her presentation by discussing the DHCFP organization chart from page 6 of Exhibit E and the executive team leaders that oversaw various functions.

Vincent "Budd" Milazzo, Chief Financial Officer, DHCFP, DHHS, introduced page 7 and page 8 of Exhibit E and provided an overview of the 2019-2021 biennial budget, along with comparisons to the 2017-2019 legislatively approved budget. The total budget funding increased from $8,310,003,602 in the 2017-2019 biennium to $9,548,349,934 in the 2019-2021 biennium. There were several funding streams, he noted, but 71 percent of the 2019-2021 budget was comprised of federal dollars. Of the nearly $400 million State General Fund increase compared to the 2017-2019 biennium, $120 million was because of the Federal Medical Assistance Percentage (FMAP) changes, $120 million was due to caseload increases, $78 million resulted from inflation, and $9 million was based on mandates. Page 8 of Exhibit E broke down the funding sources for fiscal year (FY) 2018.

Page 9 of Exhibit E, Mr. Milazzo said, indicated where Medicaid had spent the majority of the dollars for services in FY 2018. The largest portion was spent on per-member, per-month premiums to the managed care organizations. Of note, he said, those organizations also paid the state insurance premium tax which contributed approximately $62 million directly to the State General Fund annually. The blue bars on the chart represented fee-for-service expenditures for several service areas.

Page 10 of Exhibit E, according to Mr. Milazzo, was a summary that broke down the budget recommendations into the five budget accounts within the Division. With the Nevada Check Up Program and the Nevada Medicaid Program, there was an increase in State General Fund dollars needed as the FMAP decreased. He repeated Mr. Whitley's statement that as the economy improved, the FMAP decreased and the State General Fund portion had to increase.

Mr. Milazzo highlighted page 11 and page 12 of Exhibit E and discussed information regarding the covered populations. Page 11, he said, illustrated the caseload breakdown by category, and page 12 showed the cost per recipient within those categories for FY 2018. He said that parents and children who were the traditional Medicaid population were the largest portion of recipients and also the least expensive. The second largest group was the newly eligible adults which was established when Nevada chose to expand Medicaid following passage of the Patient Protection and Affordable Care Act. This group also received a higher FMAP. The last group, he said were the aged, blind, and disabled group that covered individuals who were eligible because of a disability and who made up the most costly group to cover. Of these three largest groups, only the aged, blind, and disabled category did not have the option of participating in the managed care program. Page 12 detailed the cost per recipient for each of the categories or groups.

Page 13, Mr. Milazzo said, showed the historical and projected FMAP percentages. The FMAPs were based on a federal fiscal year except for the newly eligible adult group which was set on a calendar year. This chart reflected the blended percentages which converted the federal fiscal year and the calendar year FMAP rates to state fiscal year rates for budgeting purposes. As the economy performed better, he stated again, the FMAP decreased. As discussed earlier, had the FMAP rates remained at the FY 2019 levels, the State General Fund budget recommendation would have been $120 million lower.

Ms. Phinney referred to page 14 of Exhibit E, for the projection of the Medicaid caseload through the 2017-2019 biennium and explained that The Executive Budget anticipated nearly 700,000 clients through FY 2021. Page 15 of Exhibit E, illustrated the Nevada Check Up Caseload which tended to grow as the economy improved. Children came off Medicaid and moved into the Nevada Check Up group when family income increased. She said that approximately 30,000 children were currently covered under this growing program.

Ms. Phinney explained that page 16 of Exhibit E covered Waiver Slots. Waivers were a mechanism that allowed Medicaid to design and provide services that would not otherwise be covered. The DHCFP had three waivers with its federal partner, the Centers for Medicare

and Medicaid Services. She stated that populations with specific needs were served through these waivers, including the frail elderly, individuals with intellectual disabilities, and the physically disabled. The waivers were conducted in collaboration with DHCFP's sister agency, the Aging and Disability Services Division (ADSD). This collaboration allowed those waiting to participate in the waivers to be addressed. Page 16 showed the numbers related to waitlists, she said, and more information would be provided by ADSD.

Ms. Phinney discussed the summary of major enhancements, as shown on page 17 of Exhibit E. The enhancements were categorized into three groups. The first major enhancement ensured access to care through rate increases. Medicaid covered more than half of the births in Nevada, and Neonatal Intensive Care Unit (NICU) and Pediatric Intensive Care Unit (PICU) services were critical. There was a disproportional number of births that required services from these units. If the services were not available in Nevada, then families would have to work through having a severely ill child, and also would have to seek services far from home. She noted a 25 percent increase for NICU per diem services, and a 15 percent increase for the PICU. The second part of the first enhancement, she said, had two pieces related to allowing people to manage their care in their homes using home and community-based services as they age. Those services included rate increases for personal care services and supported living arrangements. The increases were aligned with rates provided by ADSD.

The second major enhancement, Ms. Phinney stated, was aimed at continuing the transformation of a system to allow for the community maximization of services available for persons struggling with homelessness, addiction, and or mental illness. The second enhancement included an expansion of the certified community behavioral health clinics and supportive housing services for the homeless that Medicaid would reimburse. She noted that according to federal regulations, DHCFP was not allowed to pay for actual housing, but DHCFP could help people learn skills or provide the services needed to help people stay housed.

The last major enhancement group, Ms. Phinney continued, was aimed at quality initiatives. The first item was an electronic visit verification system as mandated by the federal 21st Century Cures Act. The system verified the provider was in the home, the services were received, and the reimbursement occurred in an automated and efficient manner. The second item was a program integrity initiative that expanded the capacity to work with providers and ensure that federal and state policies were executed appropriately and that the services were reimbursed appropriately.

Ms. Phinney stated that the next three pages of Exhibit E were included at the request of the Legislative Counsel Bureau. Page 18 included a description of the structural funding changes that aligned Medicaid's budget with other entities such as the FMAP program, and county programs including the voluntary contribution and the county contribution.

Page 19, Ms. Phinney continued, was a brief description of the Intergovernmental Transfer Programs. The DHCFP participated in an array of programs that allowed DHCFP to leverage the FMAP with local government funds rather than the State General Fund. Once the additional federal revenue was brought in, DHCFP would recognize increased quality and reimbursement for various services. She noted that there were potential changes to programs. The Disproportionate Share Hospital allotments were changing based on the national aggregate, and the Managed Care Enhanced Rates would be phased out by 10 percent each year through 2027 based on changes in federal rules.

Page 20 of Exhibit E, Ms. Phinney explained, was an overview of the Skilled Nursing Facility Provider Fee. The Governor's budget contemplated a 5.9 percent growth in the fee revenue based on the projected growth of the industry. Some proposals included changing the federal allowable maximum amount of these types of fees, but those had not gone into effect. The current maximum amount for the Nevada Skilled Nursing Facility Provider Fee was 6 percent. That fee, she noted, allowed for an increase in the quality of services and also improved the availability of those services.

Ms. Phinney concluded with Page 21 of Exhibit E, the Bill Draft Requests. There were two requests that helped with the clean-up and alignment with post-Affordable Care Act realities in healthcare.

Assemblyman Kramer asked about the Electronic Visit Verification System shown on page 17 of Exhibit E. He wondered whether, for instance, a provider who claimed to have provided assistance when the provider did not provide any service or assistance was an example of Medicaid fraud and whether there were enforcement mechanisms in statute. He also wondered whether the system could avoid fraud or follow up on fraud. Ms. Phinney indicated that there was a difference between fraud and misuse or abuse or even lack of knowledge, but all these situations were addressed with the program integrity efforts. The personal care services system would receive the electronic visit verification first, for example, when someone entered a client's home and assisted with light housekeeping or meal preparation. Historically, that was recorded by paper documentation. The new system would be web-based, perhaps through cell phones, would identify the location, and would create an electronic record that unlike a notebook, would not be lost or misplaced. Mistakes could still happen with data entry errors, but this would address the lost paper documentation and help to maximize the veracity of those types of records.

Senator Cancela asked about the number of autistic people who were receiving care through managed care coverage. Ms. Phinney said she could get the data from the three providers, but she acknowledged confusion because fee-for-service and managed care treated autism services differently.

Senator Kieckhefer referred to the continuation of the community-based waivers. He asked whether there was a need to reapply for the waiver because it was expiring at the end of the fiscal year, and he asked whether there was a risk associated with the waiver not being

extended. Ms. Phinney confirmed that the waivers did expire periodically and were renewed. She explained that they were in the process of renewing a waiver now, with another to be renewed soon after, and she did not expect any problems with the renewals.

Senator Goicoechea asked for the percentage of children born in Nevada who were covered by Medicaid. Suzanne Bierman, Administrator, DHCFP, Department of Health and Human Services (DHHS) replied that her understanding was that the number was more than half, at 56 percent.

Chair Carlton noted that discretionary rate increase discussions in the future would require a lot of data, including what other states were doing and what the basis for the rate was. Because she wanted the Ways and Means Committee and the Human Services Joint Subcommittee to be able to dig into the numbers, she expected the DHCFP testifiers to be prepared to provide the data. Ms. Bierman stated that she would have the data ready.

Chair Carlton recessed the meeting at 10:31 a.m. and reconvened the meeting at 10:44 a.m. The Chair introduced the next presentation.

Steve H. Fisher, Administrator, Division of Welfare and Supportive Services (DWSS), DHHS, said his presentation would include a high level overview of (Exhibit F), "Department of Health and Human Services, 2020-2021 [2019-2021], Governor Recommends Budget, Pre-Session Budget Hearing, Welfare and Supportive Services," dated January 23, 2019. He explained that his presentation would answer all the points as requested in the Subcommittee's instructions.

Mr. Fisher began by referring to page 2 of Exhibit F, the mission of DWSS. The primary mission, he summarized, was to provide public assistance to all who qualified. This was the eligibility component of the operation: eligibility was determined for the Supplemental Nutrition Assistance Program (SNAP), the Temporary Assistance to Needy Families (TANF), Medicaid, the Energy Assistance Program, the Child Care Subsidy Program, and the Child Support Enforcement Program.

Page 3 of Exhibit F, Mr. Fisher stated, was the organizational chart, and page 4 illustrated the Division's accomplishments over the past several years. The accomplishments occurred in three general areas; program improvement, customer service improvements, and efficiencies. He highlighted that the Child Support Enforcement Program had improved from 25th in the nation to 13th in the nation. He acknowledged that meeting the All Family Work Participation Rate in 2018 was a significant accomplishment, as was the integration of the Employment and Training program and the childcare case managers into the One-Stop system. Mr. Fisher stated that the customer service improvement accomplishments played a significant role in SNAP receiving a $1.5 million bonus. For the last group, technology improvements had improved efficiencies for both clients and staff.

Page 5 of Exhibit F, Mr. Fisher said, showed a summary of agency operations, broken down into five operational areas, plus administrative services. Page 6, he continued, was a chart showing the Division's sources of funding. He noted the "other" funding source included the universal energy charge for the Energy Assistance Program, the Child Support state share of collections funding, and any fees collected.

Robert Thompson, Deputy Administrator, DWSS, DHHS, said that page 7 of Exhibit F provided TANF projections, and reported the TANF caseload was trending down slightly. He reminded the audience that 70 percent of the TANF caseload was children, and almost half of those children were being raised by a nonparent. For example, assistance was provided to grandparents raising children when the parents were not in the life of the child. The grandparents were not expected to participate in the Employment and Training programs.

Page 8 of Exhibit F, Mr. Thompson said, was the TANF block grant source-and-use document for programs that met the four purposes of the TANF program. The majority of the program funding came from the federal government block grant, and any adult receiving TANF benefits was required to participate in the work programs. The work participation rate goals were 50 percent for all families, and 90 percent for two-parent households. Nevada had struggled to meet those goals: since 2007, the state had not been able to meet the two parent goal of 90 percent, and for all but four years from 2007-2017, had not been able to meet the all-family participation goal. In 2018, as Mr. Fisher had noted, the all-family work participation rate goal was reached, and he was waiting for formal notice from the Administration for Children and Families (ACF), United States Department of Health and Human Services, that DWSS had moved out of sanction status. Nevada was currently facing an accumulated $19.5 million penalty from 2007, but had entered into a Request for Waivers from those penalties because of the economic turndown in many of those years and reasonable cause for other years. If the waivers were not approved, DWSS would be initiating corrective compliance with ACF. Corrective compliance, he clarified, would be measured on current work participation rate, which Nevada was now meeting, and because DWSS anticipated meeting the all family participation goal as well, the majority of penalties would be waived.

Page 9 of Exhibit F, the Medicaid Projections, according to Mr. Thompson, illustrated a small projected increase in the number of recipients through the 2019-2021 biennium. Page 10 displayed the SNAP projections which included a category of recipients known as Able-Bodied Adults Without Dependents. This group was aged 18 to 49 and had time limits to be able to receive food stamp assistance. Nevada had a waiver from these time limits that expired December 31, 2017. He noted that Senate Bill 323 (S.B. 323) of the 79th Session (2017) required DWSS to reapply for the waiver every year. Last year's waiver was approved for the current year for every county except Washoe. A waiver had been requested for the remainder of 2019, and a subsequent waiver request would be made, he said.

Page 11 of Exhibit F, Mr. Thompson stated, highlighted programs that provided a small supplemental payment for aged, blind, or group home recipients who also received supplemental security income. The DWSS administered these funds, with the cost of living increases split between the facilities and the individuals. He anticipated a small caseload increase as the aged population increased.

Mr. Thompson addressed Page 12 of Exhibit F, the Energy Assistance Program. The Energy Assistance Program anticipated the same funding level for the 2019-2021 biennium, and the caseload was expected to remain consistent with those funding levels.

Nova Murray, Deputy Administrator, Field Operation Support, DWSS, DHHS, discussed page 13 of Exhibit F regarding child care projections. Ms. Murray noted the current projection was trending up and indicated a waitlist would need to be created on or about December 2020 to reduce the caseload by about 6,500 children. There was a change in funding in federal fiscal year 2018 because DWSS had received a two-year budget deal that included a $21 million increase in discretionary funding for the child care program. Nevada received the notice and the grant award in 2018 and DWSS was notified that it would continue to receive the award in 2019. However, Ms. Murray stated that DWSS did not have the grant award at this time, and there was no indication that increased funding would continue for the 2019-2021 biennium. Additionally, there was a work program pending with the Interim Finance Committee next week that could affect this budget.

On Page 14 of Exhibit F, One Shot Initiatives, Ms. Murray noted that the budget recommended continued support for the Child Support Replacement System. All vendors had been hired and the planning phase and requirements validation and verification were complete. The design phase was the next step, and the project was on scope and within budget.

Steve H. Fisher, Administrator, DWSS, DHHS, explained that page 15 of Exhibit F was the Summary by Budget Account. Page 16 was a summary of major enhancements and focused on improving three areas. The first, program access, included improving access to the TANF program and the child care program. The second enhancement focused on program efficiency, primarily improving the efficiency within the Energy Assistance Program by streamlining the business process. Because of the efficiencies achieved in the Child Support Enforcement's State Collection and Disbursement unit, four vacant administrative assistant positions would be eliminated. The third enhancement was dedicated to program administration. A shortfall in the Child Support Enforcement's state share of collections reserve resulted in the elimination of 52 child support enforcement positions from the adjusted base. The recommended enhancement would reestablish the 52 positions.

Mr. Thompson said that page 17 of Exhibit F was a snapshot of the position summary for DWSS, including a recommendation for additional positions. He said there were small adjustments based on efficiencies created in DWSS and additional positions were recommended based on caseload growth.

Page 18 of Exhibit F, Mr. Thompson said, was a Venn diagram of the DWSS recipients by program. He indicated that 90 percent of Supplemental Nutrition Assistance Program (SNAP) recipients received other program assistance. While there were 736,417 separate individuals served by DWSS, most of those overlapped into other programs. Very few recipients received assistance from only one program, except for the Medicaid program. Medicaid was the only program with a large number of recipients only receiving Medicaid, many of whom were working Nevadans.

Page 19 of Exhibit F, Mr. Thompson continued, showed the work that DWSS performed and how the work was tracked. Historically, DWSS had worked under a caseload model with staff assigned to manage a fixed number of cases. Under the newer, more efficient task model, which was put in place a few years ago, DWSS was able to let the computer system perform most of the case management, allowing staff to only work on one task at a time. Management was able to track all work performed at all times, and knew exactly how long it took to complete various tasks. On average, he clarified, it took 54.02 minutes to complete each task. He knew that 58 percent of the tasks being completed were for determining eligibility and initiating case management, 19 percent of the tasks were clerical, and 23 percent were supervision and oversight tasks. Oversight was not specifically focused on management, but also quality control, quality assurance, and investigations. Investigations covered everything from clients to merchants who were not using a program appropriately, and protected the integrity of the programs.

Mr. Thompson stated that the 736,417 individuals participating in DWSS programs per month created an average of 144,007 tasks per month. For comparison purposes, he said, had DWSS not moved to the task-based model and stayed with the caseload model that required staff to manually move cases around, DWSS would have been looking for approximately 300 additional positions. The task model was more efficient, and he was hoping to expand the model to other services, including the Energy Assistance Program.

Page 20 of Exhibit F, Mr. Thompson stated, showed the tasks broken out. Tasks were tracked closely and carefully. He said that out of the 144,007 tasks performed, approximately 138,000 were handled through the call center and eligibility offices (noncalls). He knew that call center calls took approximately 36 minutes each, and there were approximately 34,000 to 35,000 calls per month. The noncalls took approximately 55 minutes each because it took longer to assist an individual in person than it did on the phone.

The DWSS' Employment and Training area required the most intense effort and included social workers and employment and training specialists. Serving those clients took an average of 146 minutes per month. Some may take up to an hour a day or an hour a week. Some clients became employed, and staff touched base with these individuals once a month for 15 minutes to offer support services and to confirm the individual was continuing to work and improving their life. Through system efficiencies, DWSS recommended a clerical staff

reduction of nine positions and an increase in family services specialist staffing of 26 positions. An additional 5 positions for oversight and support would also be required, for a net increase of 22 positions.

Mr. Fisher concluded the presentation by referring to page 21 of Exhibit F and explained that there were three Child Support Enforcement program Bill Draft Requests (BDR). Two of the BDRs were policy-based and one was a budget BDR.

Chair Carlton asked about Page 10 of Exhibit F, the SNAP "cliff" and whether that was for the able-bodied SNAP recipients. Mr. Thompson replied the Able-Bodied Adults Without Dependents were Nevadans receiving SNAP assistance, aged 18 through 49 without children, not disabled, and not working at least 20 hours per week. Nevada and other states had waivers in place, and Nevada's waiver expired on December 31, 2017. Through Senate Bill 323 (S.B. 323) of the 79th Session (2017), the DWSS was required to request a waiver to keep all the recipients on assistance without time limits. The waiver was requested and approved except for Washoe County. On January 1, 2019, benefits for those 18 to 49 year olds living in Washoe County became time-limited. Nevadans living in other counties were not time-limited. The current waiver was set to expire December 31, 2019; however, under S.B. 323 of the 79th Session, the DWSS would be requesting another waiver to extend as many Nevadans as possible for another year.

Chair Carlton asked why Washoe County was not included in the waiver. Mr. Thompson said that the Food and Nutrition Service, United States Department of Agriculture (USDA) denied the request for Washoe County based on the economic growth in that county. Chair Carlton understood that the decision was based on economic growth, but she wondered whether the USDA took into account the cost of living increase that went with the growth, the fact that people were being priced out of housing, and other economic factors in Washoe County. She was disappointed that one county was segregated out of the equation. Mr. Thompson stated that the calculations were fully based on the unemployment rate in each county. Washoe County's unemployment rate had dropped below the threshold, and that was the reason for the denial.

Chair Carlton asked how many persons were affected by this denial. Mr. Thompson said that projections indicated that about 3,700 clients would move into the time-limited category. He also wanted to point out that under S.B. 323 of the 79th Session, the DWSS was working to provide a soft landing for those 3,700 individuals. Through community partners, nonprofits, and food banks, DWSS was providing a path that offered a chance for the continuing receipt of SNAP benefits through workforce development and volunteerism.

Assemblywoman Monroe-Moreno referenced the child care projections on page 13 of Exhibit F. She wondered about the 2018 grant and why the award was not received for 2019. Ms. Murray explained that in federal fiscal year (FFY) 2018 there was an increase to an existing grant through a two-year budget deal from the federal government. In that deal, there was an additional $21 million in discretionary funding, compared to the existing discretionary funding. The notice of grant was received, and DWSS was spending the funds.

The DWSS was notified that funding would be available in FFY 2019, although the notice of grant award had not yet been received. The DWSS was told the funding may not continue, so the budget presentation used the 2015-2017 biennium funding scenario.

Assemblywoman Monroe-Moreno referred to page 17 of Exhibit F relating to the Child Support Enforcement Program. She asked about the reduction of four positions in that program and whether the four displaced people would fill any of the 22 new positions recommended as shown on page 20 of Exhibit F. Mr. Thompson clarified that the four eliminated positions were all vacant positions.

Assemblywoman Neal asked whether the federal requirements allowed for the use of subgroup data. As an example, if Mr. Thompson was in Washoe County and he realized that there were higher unemployed subgroups, she wondered whether he was allowed to tweak the numbers and carve out subpopulations who needed service, even though the overall unemployment rate might not warrant service. Mr. Thompson replied that the Able-Bodied Adults Without Dependents' (ABAWD) regulations allowed Nevada to exempt up to 15 percent of the ABAWD population, who were then allowed to remain on assistance without the time limits. He said that S.B. 323 of the 79th Session prioritized the 15 percent for Nevada, so DWSS did not have the discretion to make any changes; however, he felt the rules were logical for the groups.

Chair Carlton asked about how the TANF block grant could be affected by the partial shutdown of the federal government. She asked for information about the time frame and the discussions. Mr. Fisher replied that TANF was a block grant, and the current situation with TANF was okay because of the reserves from a prior block grant received last year. After passage in both houses, he said, a bill had been sent to the President of the United States to extend both TANF and the child care program to June 30, 2019. He anticipated approval and a signature. If the bill was not approved, DWSS would continue to use the TANF reserves to fund the benefit.

Chair Carlton asked for an update on the reserves, saying it was not a good time to be relying on an anticipated signature. Mr. Fisher said that according to the source and use records, there was $45 million in reserves.

Hearing no more questions, Chair Carlton recessed the meeting at 11:12 a.m. and reconvened the meeting at 1:35 p.m. The Chair called for the next presentation.

Julie Kotchevar, Ph.D., Administrator, Division of Public and Behavioral Health (DPBH), Department of Health and Human Services (DHHS), introduced her PowerPoint presentation, "Department of Health and Human Services, 2020-2021 [2019-2021] Governor Recommends Budget, Pre-Session Budget Hearing, Division of Public and Behavioral Health," dated January 23, 2019, (Exhibit G). Page 2 of Exhibit G, she said, included the DPBH mission, vision and philosophy. She wanted to draw attention to the philosophy that used a population-based approach to improve the health and well-being of all Nevadans.

Page 3 of Exhibit G, Ms. Kotchevar said, showed an organizational chart and staff email addresses. Page 4 and page 5 of Exhibit G showed the accomplishments, and she expressed gratitude for passage of Assembly Bill 388 (A.B. 388) of the 79th Session (2017). That bill allowed DPBH to screen 2,500 additional women for breast and cervical cancer, and the bill lowered the screening age to 40 years of age. The federal funding in comparison had a minimum age of 50 years for women. Early detection was important for improved health outcomes and had made a significant difference for women in Nevada.

Ms. Kotchevar said she was also grateful for the family-planning funding. This funding allowed DPBH to support multiple rural-based agencies as well as test some innovative practices in Nevada. In the north, DPBH extended family-planning services to inmates in the Washoe County jail in collaboration with Washoe County Health District to give women in jail an opportunity to exert control over part of their lives. The Southern Nevada Health District had a mobile family-planning service that visited underserved areas.

Ms. Kotchevar said that DPBH, along with the Southern Nevada Health District, offered a Rural Mobile Health Clinic, along with a Medicaid partnership, that recognized dental hygienists with a public health endorsement. The endorsement allowed DPBH to provide additional dental services in significantly underserved areas.

Ms. Kotchevar explained that DPBH was able to collaborate with Medicaid to create the Certified Community Behavioral Health Clinics. She hoped to expand this function going forward, but there were three clinics currently operating. This was the only other safety net mental health service that operated similar to the state facilities and accepted clients regardless of the ability to pay. These community-based clinics offered safety net services, such as targeted case management.

Ms. Kotchevar noted that DPBH had established the first behavioral health community integration plan for adult and children's mental health services, and because of Senate Bill 192 (S.B. 192) of the 79th Session (2017), she was able to extend the mobile outreach safety team hours which were now from 8 a.m. to midnight. Last year the team responded to 4,533 calls statewide.

The next accomplishment, Ms. Kotchevar said, was the establishment of a hub-and-spoke model for treatment of opioid-use disorder and access to medication-assisted treatment. The final accomplishment was support of prescriber education and adoption of prescribing protocols, she said, following passage of Assembly Bill 474 of the 79th Session (2017).

Page 6 of Exhibit G, according to Ms. Kotchevar, was the summary of agency operations, including public health functions such as HIV and communicable disease prevention, epidemiology, immunizations, chronic-disease management, and internal child health. She noted that health care facilities and several health care professions were regulated.

For direct services, she said that DPBH operated the civil and forensic mental health hospitals in the north and south. Finally, the agency operations covered behavioral health policy functions including substance abuse.

Page 7 of Exhibit G, Ms. Kotchevar noted, covered three major initiative areas. The first was community mental health services. This initiative looked at collaborating with Medicaid to expand access to community behavioral health clinics that provided integrated physical and mental health services in a single setting. The health centers were community-based and more likely to be in a location where people lived. Community-based clinics were successful at reducing the stigma for those seeking mental health services.

The next major initiative, Ms. Kotchevar said, was expansion of the mental health crisis response. The recommended budget included expansion of the mobile outreach safety teams to 24/7 operations. Also included was funding to sustain the Rural Children's Crisis Response Team and expand the behavioral health crisis stabilization services to adult populations. Ms. Kotchevar stated that the last major initiative focused on women's health and included continued funding for cancer screenings and an appropriation for family planning.

Page 8 of Exhibit G, Ms. Kotchevar noted, was a breakdown of the funding sources, showing federal funds, State General Fund, fees, and transfers that comprised the "other" category. The funding in each year of the 2019-2021 biennium, she stated, was approximately the same.

Page 9 through page 11 of Exhibit G, Ms. Kotchevar continued, showed the caseload charts which indicated that the Division budgeted at maximum capacity.

Ms. Kotchevar updated Subcommittee members on recommended addbacks which restored funding for reductions made to DPBH budgets during the 2017-2019 biennium, as shown on page 12 of Exhibit G. All of the addback services were at 100 percent of capacity, which demonstrated that funding for the addback items was needed.

Page 13 of Exhibit G, Ms. Kotchevar remarked was a summary of the budget accounts, and page 14 of Exhibit G was a summary of major enhancements. The first group of major enhancements was staffing increases for DPBH. These enhancements were based on the reconciliation of positions to reflect the caseload served and, particularly for inpatient services, to reflect service to people with more complex needs and more than one diagnosis who were more difficult to serve. Staffing ratio adjustments required for inpatient services included 16 new positions to ensure safe settings in hospitals. She noted there was also a recommended two-grade increase for forensic specialist 3 and 4 positions in this enhancement because the positions required Peace Officers' Standards and Training (POST) certification. The existing grade did not reflect the POST certification, the education required, the work performed, or the difficulty in recruiting and retaining quality staff.

The second area of focus was DPBH expanded services. Expanded services included an increase to 24/7 coverage for the mobile outreach safety teams while sustaining the Rural Children's Mobile Crisis Response Team and expanding rural coverage to include adults who might be diverted from hospital care.

On page 15 of Exhibit G, Ms. Kotchevar continued her overview of major enhancements for public health programs. She noted there was a $3 million recommendation for increased funding in each year of the biennium for family planning, particularly dedicated to outreach education, including prenatal care. Other public health program recommendations included continued funding to allow the Women's Health Connection Program to screen women as young as 40 years of age and to transfer the Problem Gambling Prevention and Treatment program to the Behavioral Health, Wellness and Prevention Program. Continuing on page 15, Ms. Kotchevar explained that the regulatory program enhancement included additional staff. Although there had been progress to become current with health inspections, there was a need for additional staff to keep up with inspections and to respond to complaints in a timely manner.

The position summary on page 16 of Exhibit G, Ms. Kotchevar said, included an increase of 35 positions.

Chair Carlton asked Ms. Kotchevar to provide a revised page 11 from Exhibit G with corrected data. The Chair mentioned that she was happy to see cervical cancer screenings being performed, but asked where clients were referred after screenings. Ms. Kotchevar replied that determining Medicaid eligibility was the first step. For clients who had insurance, the department could help each person navigate to health services, and in fact, there were hospitals with outreach programs for reduced cost.

Chair Carlton asked whether there were problems accessing care because she wanted Subcommittee members to be aware of any problems. Ms. Kotchevar said that she had not heard about other problems beyond the ability to access care with no payer source. She said that she would create a more comprehensive list.

Assemblywoman Titus asked about page 4 of Exhibit G, the lowered age for breast cancer screenings, and what the statistics and findings had been for the earlier age group. If no cases of breast cancer had been detected in women between the ages of 40 and 50, the funding might be hard to justify. Ms. Kotchevar stated that DPBH was keeping statistics and would provide more information and data on the findings.

Assemblywoman Titus asked about page 7 of Exhibit G, the rural mobile crisis units, and how many clients were reached in crisis at home or in school. She wondered about the number of clients served and, therefore, kept out of emergency rooms. This function served to save the state money in the long run, but she wanted to see the numbers to support the funding. Ms. Kotchevar stated that the data existed in the behavioral health chart pack, and the agency specifically looked at hospital diversion for the crisis response teams, so that information would be provided.

Assemblywoman Benitez-Thompson asked for clarification on page 14 of Exhibit G. She wondered whether the first bullet that started as "Request five Psychiatric Nurse 2 FTES (full-time equivalents)" referred to five nurses and two FTEs, or whether the five nurses were the equivalent of two FTEs. Ms. Kotchevar replied that it was five nurses at a level two classification.

Assemblywoman Neal also asked about page 14 of Exhibit G, specifically the recommended expansion of mobile outreach safety teams. She wondered whether the teams were being asked to integrate into school safety initiatives and whether the schools' intent was to bring in behavioral specialists. Ms. Kotchevar replied mobile crisis response teams, not the mobile outreach safety teams, could deploy to school settings, in the rural regions along with law enforcement in response to 3-1-1 or 9-1-1 calls, but the teams had not integrated into the Clark County School District as part of that effort.

Assemblywoman Neal asked about communicable diseases and what type of work the Division was doing with teenagers who had HIV. Ms. Kotchevar said the HIV program looked at high-risk groups, such as African-American teen males, and worked with grant-funded community partners.

Assemblyman Thompson also asked about page 14 of Exhibit G. For mobile outreach safety teams, he wondered about the collaboration with the continuum of care and within different jurisdictions regarding the homeless and chronic inebriates. Ms. Kotchevar replied that the Division had collaborative agreements with the different continuum of care and community-based groups to respond to calls in the Las Vegas valley. Along with the collaboration agreements, there was also a formal agreement with Las Vegas Fire and Rescue.

Assemblyman Thompson asked who comprised the outreach safety team. Ms. Kotchevar answered that they were typically licensed clinical social workers, the same trained staff that worked with first responders to respond to emergencies. She agreed to check on the number of licensed clinical social workers.

Chair Carlton asked about the addback dollars. She requested data to support the numbers because this information would help to determine the next steps. She recognized that there was a greater need, but knew that the Subcommittee on Human Services would need to evaluate what had happened.

Hearing no other questions, the Chair called for the next presentation.

Ross E. Armstrong, Administrator, Division of Child and Family Services (DCFS), Department of Health and Human Services (DHHS), stated that his presentation would include a brief overview of (Exhibit H), "Department of Health and Human Services, 2020-2021 [2019-2021] Governor Recommends Budget, Pre-Session Budget Hearing,

Division of Child and Family Services," dated January 23, 2019. He explained that page 2 of Exhibit H covered the vision and mission of the Division. The vision, he said, was nine simple words that required a heavy lift; the dedicated staff worked toward that vision every day.

Page 3 of Exhibit H, Mr. Armstrong, said, showed the DCFS organizational chart and explained a small shift from how DCFS had managed leadership responsibilities in the past. The shift was from a focus on system leadership to a focus on service and system delivery. With the new focus, one deputy administrator would concentrate on all seven residential facilities, including both juvenile justice facilities and mental health facilities; one deputy would focus on community services, including case management in the community, rural child protective and welfare services, the Youth Parole Bureau, and mobile crisis services for youth; one deputy would focus on quality and oversight and help with system planning; and one deputy would focus on administrative services, including information services, fiscal support, and the expanding grants management function.

Mr. Armstrong noted the accomplishments during the 2017-2019 biennium as shown on page 4 of Exhibit H. He said that Assembly Bill 472 (A.B. 472) of the 79th Session (2017) included a significant juvenile justice reform package. The Juvenile Justice Oversight Commission enacted in A.B. 472 had adopted a statewide risk assessment tool to be used at the training being held in southern Nevada and would be introduced in northern Nevada in two weeks. He expected full rollout in the summer of 2019.

Mr. Armstrong stated that another accomplishment was the System of Care grant that increased community resources and helped community providers set up practices. This System of Care grant would end with the federal fiscal year in September, 2019.

The last accomplishment, according to Mr. Armstrong, was the Victim Services Collaborative. During the interim, there was a large increase in Victims of Crime Act funding. The 2017-2019 biennium appropriation was approximately $30 million, and roughly five years ago, the appropriation was $3 million. The Las Vegas shooting on October 1, 2017, confirmed for Mr. Armstrong that in the federal government's eyes, DCFS as the administrator of the Victims of Crime Act, was the central point for funding victim services. There had been a disjointed funding approach, so DCFS took all agencies that funded victim services and held regular monthly meetings to streamline processes for victim service providers. This effort lessened the administrative burden on the provider agencies and resulted in the creation of a joint grant Request for Proposal timeline between the Office of the Attorney General and DCFS. This allowed service providers to plan out the year and better anticipate the grant application process.

Page 5 of Exhibit H, Mr. Armstrong continued, was the Summary of Agency Operations. This included four organizational chart functions—residential services, community services, quality and oversight services, and administrative services—with budget accounts included

under each function. To summarize, he said that DCFS provided residential services and community services through the seven facilities, and quality and oversight in all three supported systems, including juvenile justice, child welfare, and children's mental health.

Mr. Armstrong noted that page 6 of Exhibit H was included because DCFS was asked to provide an update on two areas, specialized foster care and the Desert Willow Treatment Center. For specialized foster care, during the interim, DCFS was part of a workgroup that proposed a state plan amendment for Medicaid. The effort was not successful so the state contracted with a firm to develop a home and community-based waiver for the special needs foster youth. The process continued, and the last calls to stakeholders were made yesterday with agencies and service providers. The next step would be putting structure on the services to be provided in that package, along with the qualification requirements.

For the Desert Willow Treatment Center, Mr. Armstrong continued, the original proposal from the 2017-2019 biennium was to relocate a portion of the center to an adult campus [Rawson-Neal Psychiatric Hospital] and have a private agency operate the building where the center was located now. By the time the 2017-2019 biennium ended, a decision had been made to keep Desert Willow Treatment Center as a safety net and share the facility with a private provider. A Request for Proposal was created and a contractor was selected, but regulatory and legal barriers arose, so the two parties were not able to agree on the contract terms. The recommended budget for the 2019-2021 biennium, therefore, maintained the safety net funding at approximately 20 beds until a decision was made on how best to use the remainder of the building.

On page 7 of Exhibit H, Mr. Armstrong stated, one of the three major initiatives recommended 96 new positions across the three juvenile justice facilities to comply with the Prison Rape Elimination Act (PREA). He explained that staffing compliance had been maintained through the use of overtime and through a reduction in other services. An independent work group had assessed what needed to be completed to ensure compliance, and the recommendation for 96 new positions came out of that work group assessment.

Another major initiative, Mr. Armstrong continued, was a conversion of the Division's residential behavioral health treatment centers, including the children's mental health facilities, but not the Desert Willow Treatment Center. The conversion to an official psychiatric residential treatment facility that could bill a daily rate to Medicaid would increase care for the youth served in those facilities, would create efficiencies, and would increase the ability to use Medicaid dollars.

The last major initiative, Mr. Armstrong said, was a technology investment that allowed the Unified Nevada Information Technology for Youth (UNITY) system to have bidirectional data exchanges with other computer programs. The UNITY system maintained the core functions to meet federal requirements and allowed other third party application plug-ins to allow child welfare agencies to perform their tasks. The added flexibility from this enhancement would allow for the creation of dashboards and analysis capabilities to match children to the appropriate resources.

Page 8 of Exhibit H, Mr. Armstrong explained, illustrated the breakdown of funding sources. He stated that there was a large State General Fund share because the federal government considered children in juvenile justice facilities to be inmates. Even though children received therapy and other services in the state facilities, the children did not qualify for Medicaid. He summarized that Medicaid dollars went toward the children's mental health system, shown in the "other" category, and the federal funding included Title IV-E foster care monies as well as Victims of Crime Act funding.

Chair Carlton asked about offenders in the corrections system, and she wondered whether incarcerated people, if referred to by a different name, would be eligible for Medicaid services. She was not looking for a work-around necessarily, but because the children were receiving medical services, it seemed that Medicaid should cover the children. Mr. Armstrong said that he had received direction from the Centers for Medicare and Medicaid Services that the definition of an inmate was the determining factor. Those people at the Department of Corrections who were waiting to be paroled or "voluntarily" waiting, was the factor used in determining eligibility. The Chair stated that she was curious about this, but would look at it offline.

Page 9 of Exhibit H, Mr. Armstrong continued, showed the adoption-subsidy caseload. After a family had adopted a child, DCFS provided financial support, and this was the only caseload type not rolled into the county block grants. The three different lines on the chart showed the three different child welfare agencies.

Page 10 of Exhibit H, according to Mr. Armstrong, showed the traditional family foster care caseload, along with specialized foster care and advanced foster care on the bottom of the page. Specialized foster care and advanced foster care both provided a therapeutic level of foster care, specialized foster care was provided through agencies, while advanced foster care was much more like the traditional homes. These charts reflected only paid foster care placements, so foster youth staying with a family member did not show on these charts.

On page 11 of Exhibit H, Mr. Armstrong explained that he was asked to provide census data for facilities. The second column was the average children's mental health facility populations for fiscal year (FY) 2018 and the third column identified the average populations through November 2018 for FY 2019. Page 12 of Exhibit H highlighted the juvenile justice facility populations using the same breakouts.

Page 13 of Exhibit H, Mr. Armstrong noted, was a summary by budget account. The only budget account with a significant difference in federal funding between FY 2020 and FY 2021 was Budget Account (BA) 3646 which reflected a reduction in federal funds because of the removal of the System of Care grant.

Page 14 of Exhibit H, Mr. Armstrong said, covered a summary of major enhancements. The enhancements he had not discussed previously included a series of new positions for child welfare activities associated with federal program improvement plans, mandates to meet the federal Commercial Sexual Exploitation of Children Act and the Comprehensive

Addiction and Recovery Act and licensing activities for adoptive and relative placements in rural areas. In addition, there was an increase in funding to support childcare and respite services for foster families. When foster families were recruited to help the most vulnerable children, the DCFS wanted to remove any barriers that might have existed.

Another major enhancement area, Mr. Armstrong, stated, was juvenile justice. In addition to the 96 new positions, one new criminal investigator position was recommended to conduct PREA investigations in the three juvenile justice facilities. The last enhancement was in the area of children's mental health and covered the conversion of the behavioral health treatment centers to psychiatric residential treatment facilities. This conversion allowed DCFS to bill Medicaid a daily bundled rate for services. The additional funding helped to support 24-hour nursing staff and increased the medical care children received at the facilities.

Page 15 of Exhibit H, Mr. Armstrong said, was a position summary, and he again noted that BA 3646 was the only budget account with a negative number. The negative number represented a loss of ten System of Care grant positions, partially offset by the addition of seven positions for the conversion to a psychiatric residential treatment facility. He noted that the intent was to displace or layoff as few people as possible in the process.

Page 16 of Exhibit H, Mr. Armstrong noted, was a Bill Draft Request (BDR) that would place Nevada in compliance with federal law and would allow child welfare agencies to retain the savings realized from adoption that then had to be reinvested into child welfare agencies. Every adoption resulted in a cost savings. This BDR would provide the budget mechanics for those funds to be reinvested into the child welfare system, as mandated by federal law, rather than reverting to the State General Fund.

Chair Carlton asked about page 13 of Exhibit H, Budget Account (BA) 3148, Summit View Youth Center. She had been tracking this budget account and was interested in the increase from FY 2020 to FY 2021 and whether the increase was based on caseload growth. Mr. Armstrong answered that the increase covered the new position for PREA enforcement.

Assemblywoman Benitez-Thompson referred back to the reorganization of the Division and asked whether the compliance effort would cover all functions or whether the compliance staff would be housed under each function. Mr. Armstrong replied that the quality and systems staff were housed in each of the different areas of juvenile justice, child welfare, and children's mental health. One of the struggles was that the urgency of crises can take staff away from the planning process. The compliance staff already existed, but were scattered throughout the organization. Efficiencies would be realized by centralization and would help to provide more uniform approaches to quality assurance and processes. Over time, he hoped to strategically look at the internal organization structure.

Assemblyman Kramer asked about page 10 of Exhibit H, and the differences among specialized foster care, advanced foster care, and family foster care. Mr. Armstrong said that all three types of foster care were licensed and received support from DCFS. Family foster care was the traditional foster care method after an allegation of abuse or neglect. Under

family foster care, the child was removed from the family and temporarily placed while DCFS worked on reunification or case-planning with the family. To qualify for specialized foster care or advanced foster care, there were four qualifying triggers related to behavioral health and mental health matters. These two types of foster care both required foster care with substantial services. In Nevada, there was a decision that the Together Facing the Challenge model was the best service delivery model for the therapeutic level of foster care and must be used in both the specialized foster care and the advanced foster care homes.

Assemblyman Kramer asked how specialized foster care differed from advanced foster care. Mr. Armstrong replied that specialized foster care was operated by foster care agencies. A foster care agency had multiple homes and staffed the homes and supplied those homes with support. Advanced foster care was a traditional family foster care placement where the foster family had decided to take additional training to be able to provide the necessary services to the youth.

Assemblyman Kramer asked about the additional positions for supervision in the juvenile justice facilities. He noted that staff size increased from 243 to 341 with the additional positions, but page 12 of Exhibit H showed the average facility population at 210. When he assumed a four-shift day, or just under 90 employees per shift, he wondered whether 90 staff supervising 210 clients, almost a 1:2 ratio, was necessary. He asked whether an upgraded facility or increased capital investment would result in a better staff-to-client ratio. Mr. Armstrong replied that the PREA mandated ratio for staff to juvenile clients was 1:8 during the day and 1:16 at night. He assumed three shifts, which justified the additional 96 positions. The number of new positions considered other situations, such as leave time, and he noted that a new facility would be both costly and designed differently. He suggested building 16-bed pods instead of the 20-bed pods seen in other youth facilities.

John Muñoz, Deputy Administrator, DCFS, Department of Health and Human Services, (DHHS) stated that Mr. Armstrong was correct about the redesign, and he noted that the existing facilities were not designed to meet a 1:8 or 1:16 ratio of staff to juvenile clients. There were inefficiencies in the way the facilities were designed 50 years ago, and he acknowledged the value in Assemblyman Kramer's question. He did not know whether the answer was hiring more staff or redesigning the facilities. He added that all the states in the nation were facing the same challenges in trying to meet the PREA standards. Chair Carlton stated that the ultimate goal was to have empty pods.

Senator Kieckhefer asked about employment in Elko and Caliente. He wondered whether there was significant turnover and vacancies in those locations, and he also wondered about the recruitment results for positions in Elko or Caliente. Mr. Armstrong said the typical vacancy rate for all juvenile justice facilities was between 8 percent and 12 percent. He compared hiring in Elko or Caliente to hiring at the facility in Las Vegas and noted that there was greater competition from other employers in Las Vegas. He also added that the work was difficult and thankless, and there were more opportunities to leave employment in Las Vegas, affecting the vacancy and turnover rates.

Assemblyman Thompson asked about internal communications and how DCFS avoided duplicating efforts or resources. On a bigger scale, he asked how DCFS connected with the local communities because all groups were serving the same audience. He wanted to see where the needle was truly moving, where the statewide safety net was being strengthened, and where silos were being eliminated.

Richard Whitley, Director, DHHS, stated that he had good examples of internal communication, citing the opioid crisis as an example. There were topical matters across all divisions and all populations. He pulled together teams and identified a leader, but he acknowledged that instituting change at a local level was occasionally the toughest part. The level of organizational structure and partnerships were different in different areas. For food security, he noted, there was a strong partnership, but the homelessness situation was different in every community based on the partners at the table and who would work together. He remembered that he had been at several meetings in Clark County, and there were no local government representatives in attendance. That did not mean the meeting was not a priority for local government, but there was no system in place to ensure participation. He believed that the approach used by the Division of Public and Behavioral Health, DHHS, and the regional behavioral health boards was helping. Each community's needs and assets were different, but he would like to see something more formal in place at a local level, specifically between governments, and to identify the role of each party at the table.

Assemblyman Thompson recognized that the same conversation might occur with local governments, but he wondered how to get to a point where conversations were strategic and silos were being eliminated, without discounting the work that was being done. As a visual learner, he wanted to see the connection to local governments. He asked whether state government could be the lead or convener of this effort, and he asked how it should be done. Mr. Whitley said that data was the key to this effort. Data would ensure everyone was working on the same problem. An example he cited was the homelessness in Washoe County, the City of Reno, the City of Sparks, and the state. There was a need to move the homeless from downtown and possibly build another shelter. He noted that data drove the planning. Amber Howell from Washoe County Social Services dug into the data, determined the population breakdowns, including but not limited to homeless pregnant women, homeless young adults, and homeless families, and concluded there were winnable battles. It was the data, he summarized, which overrode emotional territory. Identifying the problem, he said, could be the convener to which Assemblyman Thompson referred. There was a data group in DHHS, but it did not appear on the organizational chart. Mr. Whitley felt he could do better at partnering with the universities. The data was rich, but the universities could analyze the data and provide more information. He expected that such an effort would be the next phase. He felt this effort would engage community stakeholders, nonprofits, and governments alike.

Assemblyman Thompson believed that he had asked a tough question, but he felt that everyone should be striving to connect everything and continue to move to that end.

Assemblywoman Monroe-Moreno referenced page 13 of Exhibit H and asked how many children, when dealing with mental health and juvenile justice, were placed at out of state facilities, and the costs associated with those placements. Mr. Armstrong replied that the costs were scattered throughout the presentation, but he would provide that data.

Chair Carlton asked for the reason children were placed out of state, as well, and what services were not available in Nevada.

Senator Cancela expressed her gratitude for work done in Clark County and Washoe County in figuring out how to get the most vulnerable children adopted and out of foster care.

Hearing no more questions, Chair Carlton opened the meeting for public comment.

Pam Berek, a private citizen from south Reno, Nevada, explained that she was a recipient of funding and services from Assembly Bill 307 (A.B. 307) of the 78th Session (2015). The services from that bill, funded by Medicaid, literally saved her life last year. She received Autism Treatment Assistance Program (ATAP) funding because her son has multiple disabilities, including autism, cerebral palsy, and catastrophic epilepsy. Her son had paradoxical reactions to all medicines, so the expected outcome never happened. Her son, therefore, was not a candidate for any medical intervention. She was receiving services from ATAP, although she did not want to say who was providing services as she had already complained to ATAP. At that point, she thought her family had used all the services that they could receive. With the start of puberty, her son developed highly aggressive tendencies, he had taken chunks out of his own skin and her skin, he had tried to rip his eyes out, and he banged his head. He did anything he could do to hurt himself or others. She stated that this was no way to live. She was at the end of her rope. Then, she was told about A.B. 307, and Sierra Regional Center took on her case. She was approved through ATAP to receive Applied Behavior Analysis (ABA) therapy. With A.B. 307 and the support from Medicaid, she wanted the Subcommittee members to know, the services and the funding had saved her life. There was a phenomenal support system available now through Helix Behavioral Services, and she could not applaud Helix enough. Helix Behavioral Services had helped turn things around and was teaching her how to better work with her son so his behavior was not as extreme. Things were getting better each day. Medicaid services, she said, were very important to families like hers.

Steven Cohen, a private citizen from Las Vegas, Nevada, returned to testify again. He offered his services to Ms. Berek to help assist her, once she had signed a Health Insurance Portability and Accountability Act (HIPAA) release form. He encouraged the Subcommittee members to look at the complete lifespan of people with autism, because without early intervention, there would be less favorable outcomes during and after the teenage years. He referenced a public safety bill for autism training and said he would be back to testify on that bill.

Hearing no other public comment in southern Nevada or in northern Nevada, the Chair closed the meeting at 2:42 p.m.

RESPECTFULLY SUBMITTED:

Carmen M. Neveau
Committee Secretary

APPROVED BY:

Assemblywoman Maggie Carlton, Chair

DATE: _____

Senator Joyce Woodhouse, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is written testimony, revised January 28, 2019, submitted by Steven Cohen, private citizen, Las Vegas, Nevada.

Exhibit D is a copy of a PowerPoint presentation, titled "Department of Health and Human Services, 2020-2021 [2019-2021] Governor Recommends Budget, Pre-Session Budget Hearing" dated January 23, 2019, presented by Richard Whitley, Director, Department of Health and Human Services.

Exhibit E is a copy of a PowerPoint presentation, titled "Department of Health and Human Services, 2020-2021 [2019-2021] Governor Recommends Budget, Pre-Session Budget Hearing, Division of Health Care Financing and Policy" dated January 23, 2019, presented by Suzanne Bierman, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services.

Exhibit F is a copy of a PowerPoint presentation, titled "Department of Health and Human Services, 2020-2021 [2019-2021] Governor Recommends Budget, Pre-Session Budget Hearing, Welfare and Supportive Services" dated January 23, 2019, presented by Steve H. Fisher, Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services

Exhibit G is a copy of a PowerPoint presentation, titled "Department of Health and Human Services, 2020-2021 [2019-2021] Governor Recommends Budget, Pre-Session Budget Hearing, Division of Public and Behavioral Health" dated January 23, 2019, presented by Julie Kotchevar, Ph.D., Administrator, Division of Public and Behavioral Health, Department of Health and Human Services.

Exhibit H is a copy of a PowerPoint presentation, titled "Department of Health and Human Services, 2020-2021 [2019-2021] Governor Recommends Budget, Pre-Session Budget Hearing, Division of Child and Family Services" dated January 23, 2019, presented by Ross E. Armstrong, Administrator, Division of Child and Family Services, Department of Health and Human Services.